

An Overview of
Medicaid Long-Term Care Programs
in New York

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Chapter 1

System Overview

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Introduction

This report provides an overview of New York State’s 12 Medicaid long-term care programs that primarily enroll frail seniors and adults with disabilities.¹ Monthly enrollment in these programs (247,000) accounts for roughly 6 percent of the state’s 4.1 million Medicaid beneficiaries.² Much of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities; care for this group can be intensive and costly. Spending for these long-term care programs was roughly \$12.3 billion in federal fiscal year (FFY) 2007, more than a quarter of all Medicaid spending in the state.^{3,4}

The state’s long-term care programs fall into two broad categories corresponding to the setting where most services are provided: residential; and home and community-based.⁵ Two-thirds of long-term care beneficiaries are enrolled in community-based programs.⁶

New York Medicaid Long-Term Care Programs Primarily Serving Frail Seniors and Adults with Disabilities

Residential Programs	Community-Based Programs
Nursing Homes (NH) Medicaid Assisted Living Program (ALP)	Traditional Personal Care (PC) Consumer-Directed Personal Assistance Program (CDPAP) Long-Term Home Health Care Program (LTHHCP) Medicaid Managed Long-Term Care (MMLTC) Program of All-Inclusive Care for the Elderly (PACE) Certified Home Health Agency (CHHA) Services Medical Adult Day Health Care (MADHC) Traumatic Brain Injury (TBI) Waiver Nursing Home Transition and Diversion Waiver (NHTDW) Medicaid Advantage Plus

Long-Term Care Population: Health Status and Demographics

In New York’s current long-term care system, it is difficult to compare key measures of beneficiary need — cognitive impairments, physical (functional) limitations, and chronic medical conditions — across care settings and among programs because this information is

¹ This system overview is a chapter of *An Overview of Medicaid Long-Term Care Programs in New York* by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates. They do not include programs that primarily serve people with intellectual disabilities or medically fragile children, such as the Care at Home Program. See the Technical Notes of the full report for a discussion of data sources and research methods.

² The 4.1 million enrollment figure is for September 2007. It does not include children enrolled through the State Children’s Health Insurance Program (SCHIP).

³ Spending was for FFY 2007 (October 1, 2006 — September 30, 2007), unless otherwise noted.

⁴ According to United Hospital Fund analysis of FFY 2007 CMS-64 and September 2007 MARS 72 data, New York State spent \$44.3 billion on Medicaid services in FFY 2007, \$12.3 billion (or 27.8 percent) of which was spent on long-term care programs primarily serving frail seniors and adults with physical disabilities.

⁵ Enrollment in two programs, the Nursing Home Transition and Diversion Waiver program and Medicaid Advantage Plus, did not begin until 2008.

⁶ For ease of discussion, people enrolled in the programs explored in this report are referred to as long-term care beneficiaries, and home and community-based programs are referred to as community-based programs.

not collected in a common format. Each program uses a different assessment tool. The extent to which cognitive impairments, physical disabilities, and chronic illnesses (and often a combination of all three) impair an individual's ability to perform activities of daily living and instrumental activities of daily living drives the need for long-term care. In community-based settings, the provision of care is influenced by other critical factors: the availability and capacity of family support; housing and living situations; and the availability of community services, such as transportation.

Although most long-term care program beneficiaries in both community-based and residential settings are 65 years of age or older, there is a sizeable population of younger beneficiaries too, who are more likely to be enrolled in community-based programs than in residential settings. For example, 83 percent of Medicaid nursing home residents are 65 or older, compared to only 59 percent of beneficiaries enrolled in community-based programs.⁷

Functional Limitations: Long-term care beneficiaries have a wide range of needs. Some function well with minimal help, while others require around-the-clock care in a nursing home or at home. There is no common measure of functional impairment in the state's long-term care programs. The most consistently available proxy is the need for nursing home level of care. [See discussion in the Eligibility section.]

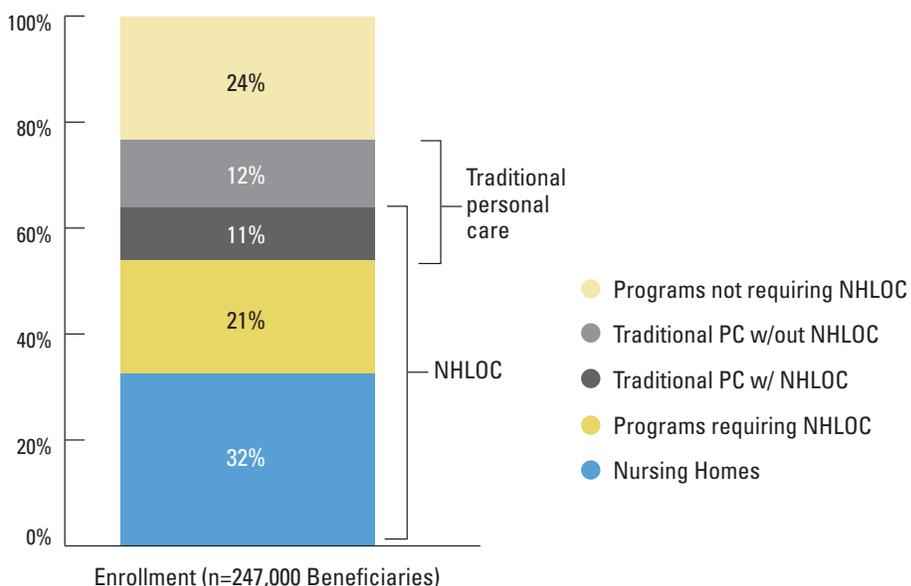
Roughly two-thirds of the state's Medicaid long-term care beneficiaries (157,000 individuals) have nursing home level of care needs. This estimate includes 79,000 nursing home residents; 51,000 in community-based programs limited to individuals with nursing home level of care needs; and an additional 27,000 in the traditional personal care program (Hokenstad et al. 2002).⁸

⁷ United Hospital Fund analysis of Medicaid reference statistics, FFY 2005-2007 (New York State Department of Health, Office of Health Insurance Programs, June 2008).

⁸ Although the traditional personal care program does not require nursing home level of care for eligibility, previous UHF research estimated that 65 percent of PC beneficiaries in New York City require such a level of care. The number of PC beneficiaries in the rest of the state who require a nursing home level of care is unknown.

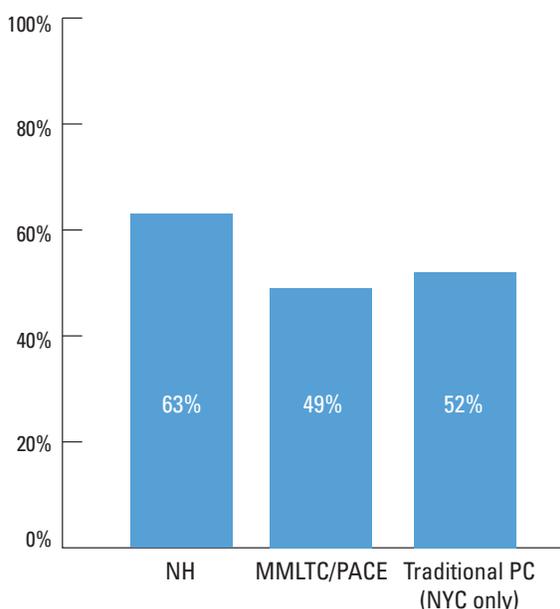
Cognitive Status: There is also no common measure of cognitive status in the state’s long-term care programs. An imperfect compilation of available data suggests that roughly two-thirds of nursing home residents and one-half of beneficiaries in community-based programs have some degree of cognitive impairment.

Figure 1.1
Medicaid Long-Term Care Beneficiaries with Nursing Home Level of Care Needs



Source: UHF analysis of Sept 2007 MARS, 2007 LTHHCP census, 2006 RHCF4 cost report, and Hokenstad et al. 2002.
 Note: NHLOC programs include ALP, LTHHCP, TBI, MMLTC, and PACE. Non-NHLOC programs include CDPAP, CHHA, and Medicaid ADHC.

Figure 1.2
Medicaid Long-Term Care Beneficiaries with Cognitive Impairment, by Program



Source: SDOH 2006 Final Report on Managed LTC; Dennison 2008; Hokenstad et al. 1997.
 Note: As previously noted, each program uses a different tool to assess cognitive impairment. We were unable to identify a valid source for extent of cognitive impairment in the LTHHCP.

Data Sources and Methods

There is no single reliable source of enrollment and spending data for New York's Medicaid long-term care programs. In order to determine the number of beneficiaries enrolled in the programs and associated Medicaid spending, this analysis relies on data from several sources.

The enrollment data comes from the New York State Department of Health (SDOH) Management and Administrative Reporting Subsystem (MARS), a monthly summary of Medicaid program statistics, for September 2007. In a few programs, an accurate beneficiary count could not be ascertained from MARS; for these programs, enrollment data comes from provider census data. The spending data comes from the Centers for Medicare & Medicaid Services (CMS) Financial Management Reports (Form 64) and the MARS for Federal Fiscal Year 2007. In this study, the CMS 64 is used where possible to report spending by service or program because it reflects an audited record of actual Medicaid payments. Because the CMS 64 does not provide sufficiently disaggregated data by service or program, the MARS data is also used. To reconcile these data sets, the share of spending by service or program from the MARS is imputed into the service category totals from the CMS 64. The analysis excludes programs that primarily enroll individuals with developmental or intellectual disabilities and those that primarily enroll medically fragile children, such as the Care at Home waiver programs.

This study's focus is long-term care as opposed to short-term post-acute care. However, two of the key providers of long-term care services — nursing homes and certified home health agencies — also provide a substantial amount of post-acute care. Available data sources do not distinguish between the two kinds of services. Because the distinction is significant for policy purposes, rough estimates of post-acute enrollment and spending are provided in the Technical Notes and in footnotes throughout this report. See Appendix II for more detail on methods and other data sources used.

Finally, for ease of discussion, this report employs a broad definition of “program.” In the current long-term care system, the distinction between covered services and the programs that provide them is hazy; the terms are often used interchangeably. Many individuals access long-term care services exclusively from a licensed service provider, such as a nursing home. Others receive them through designated “programs,” such as the Long-Term Home Health Care Program, which offer a constellation of services. In this report, “program” refers both to designated long-term care programs and to large groups of beneficiaries who access services exclusively from a licensed provider. For example, “personal care program beneficiaries” refers here to people receiving traditional personal care services and not enrolled in one of the designated long-term care programs.

Programs Highlighted in Report

This report focuses primarily on four of the largest Medicaid long-term care programs in New York: nursing homes, traditional personal care (also known as the Home Attendant program in New York City), the Long-Term Home Health Care Program (LTHHCP; also known as the Lombardi program or Nursing Home Without Walls), and Medicaid managed long-term care (MMLTC). Together, they account for 73 percent of long-term care program enrollment and 82 percent of associated long-term care spending.

This chapter presents an overview of New York’s Medicaid long-term care system, with particular focus on the four programs noted above. Chapters 2 – 5 of this report provide in-depth profiles of the programs.

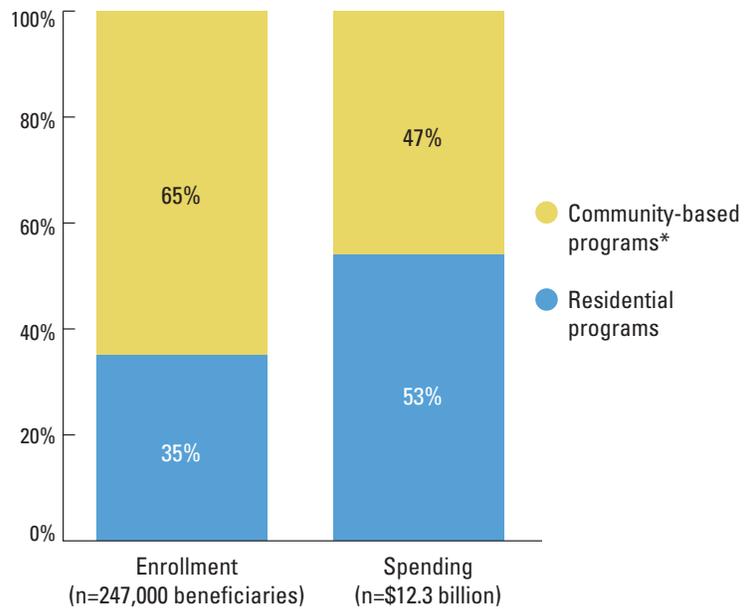
System Snapshot: Recent Data on New York’s Long-Term Care Programs

Enrollment and Spending

In September 2007, there were approximately 247,000 individuals receiving Medicaid long-term care services in programs that primarily enroll frail seniors and adults with physical disabilities. Of these, approximately two-thirds (166,000) were receiving services in community-based settings; the remaining one-third (81,000) were receiving services in residential settings, almost entirely in nursing homes.

Medicaid spent roughly \$12.3 billion on these programs in FFY 2007. Fifty-three percent of this spending (\$6.6 billion) was for residential programs, almost entirely for nursing homes. The remaining 47 percent (\$5.8 billion) was spent on community-based programs.

Figure 1.3
Enrollment and Spending in Medicaid Long-Term Care Programs, by Care Setting, 2007



Source: UHF analysis of Sept 2007 MARS, FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF cost report.

* Community-based programs include traditional PC, CHHA, CDPAP, ADHC, TBI, LTHHCP, MMLTC, and PACE programs.

Table 1.1
Summary of Medicaid Long-Term Care Program Enrollment and Spending, by Program, 2007

Medicaid LTC Programs	September 2007 Enrollment			FFY 2007 Spending		
	Number of Beneficiaries[a]	Percentage of Total LTC	Percentage of HCBS LTC	Medicaid Spending (millions)	Percentage of Total LTC	Percentage of HCBS LTC
Nursing Homes	79,000	32%	n/a	\$6,500	53%	n/a
Medicaid Assisted Living Program	2,000	1%	n/a	\$100	1%	n/a
Residential care	81,000	33%	n/a	\$6,600	53%	n/a
Traditional Personal Care	57,000	23%	34%	\$2,200	18%	39%
Certified Home Health Agencies[b]	41,000	17%	25%	\$1,300	11%	23%
Long-Term Home Health Care Program	24,000	10%	15%	\$700	6%	13%
Medicaid Managed Long-Term Care	20,000	8%	12%	\$700	6%	12%
Medical Adult Day Health Care	13,000	5%	8%	\$300	2%	5%
Consumer-Directed Personal Care	7,000	3%	4%	\$300	2%	5%
Program of All-Inclusive Care for the Elderly	3,000	1%	2%	\$100	1%	3%
TBI Waiver	2,000	1%	1%	\$100	1%	2%
Community-Based Care	166,000	67%	100%	\$5,800	47%	100%
Total LTC	247,000	100%		\$12,300	100%	

Sources: Based on UHF analysis of September 2007 MARS, FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF-4 cost report.

Notes: Enrollment is a snapshot from September 2007; spending is for FFY 2007. Categories may not sum to total due to rounding.

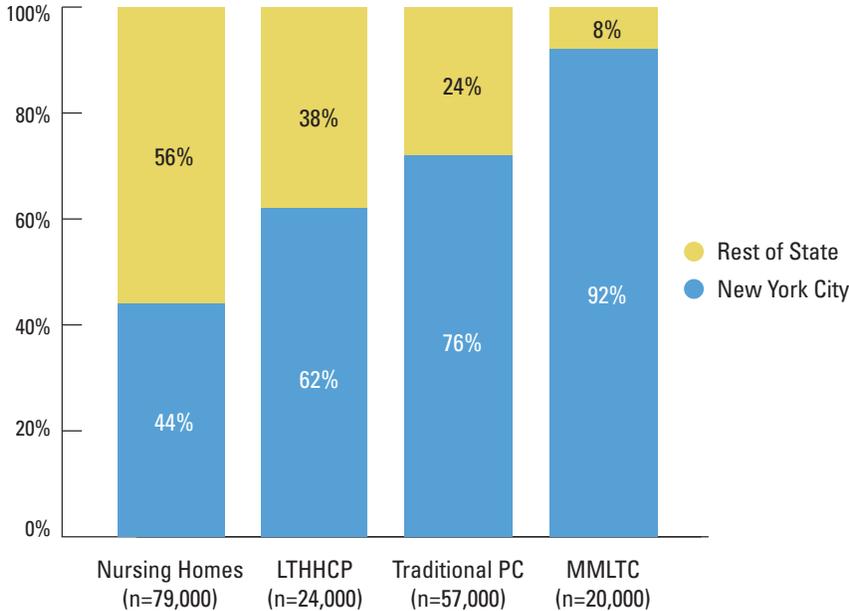
[a] Within a given month, a beneficiary may receive more than one of the long-term care services listed above; these beneficiaries have been included in enrollment figures for all such services. Therefore, enrollment totals and subtotals include some duplication in the number of LTC beneficiaries. According to UHF analysis of SDOH data, there is approximately 6 percent duplication across all long-term care programs; less than 1 percent duplication in residential programs; and almost 10 percent duplication in community programs. See Technical Notes for additional detail.

[b] Reported CHHA enrollment and spending figures for September 2007 include some short-term (typically post-acute) care recipients, defined here as beneficiaries who received home health care in September but not in each of the previous three months (June, July, or August 2007). According to an SDOH/OHIP analysis, 31 percent of Medicaid CHHA recipients were receiving such short-term home health care; this population accounted for approximately 16 percent of all reported CHHA spending in September 2007. An undetermined amount of short-term care is also included in nursing home enrollment and spending figures.

New York City vs. Rest of State: There are wide geographic differences in program enrollment and spending patterns between New York City and the rest of the state. Most enrollment in community-based programs is in New York City, while most nursing home enrollment is elsewhere in the state.

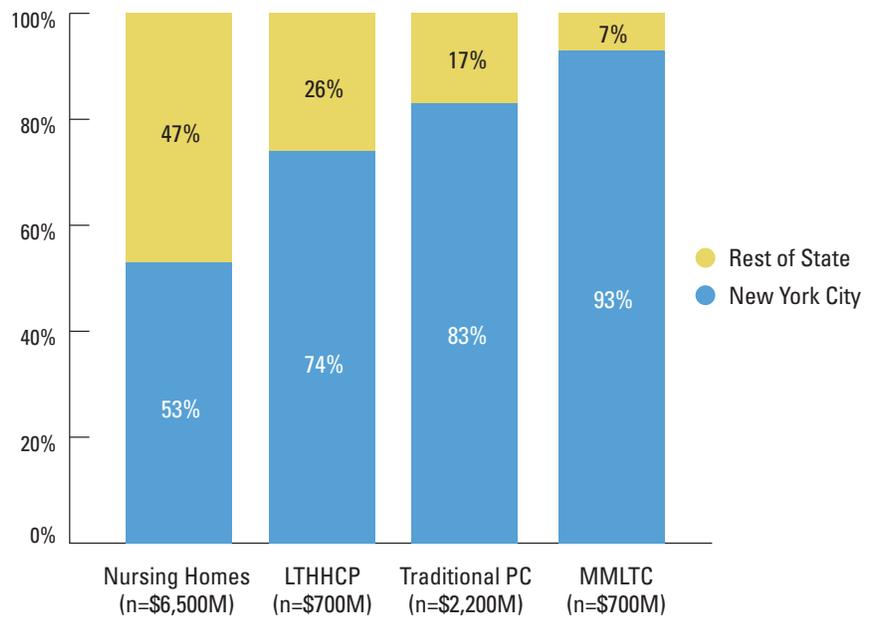
New York City also accounts for most long-term care spending. The proportion of spending in New York City compared to the rest of the state ranges from 53 percent of nursing home expenditures to 93 percent of Medicaid managed long-term care expenditures.

Figure 1.4
Share of Medicaid Long-Term Care Program Enrollment in New York City,
September 2007



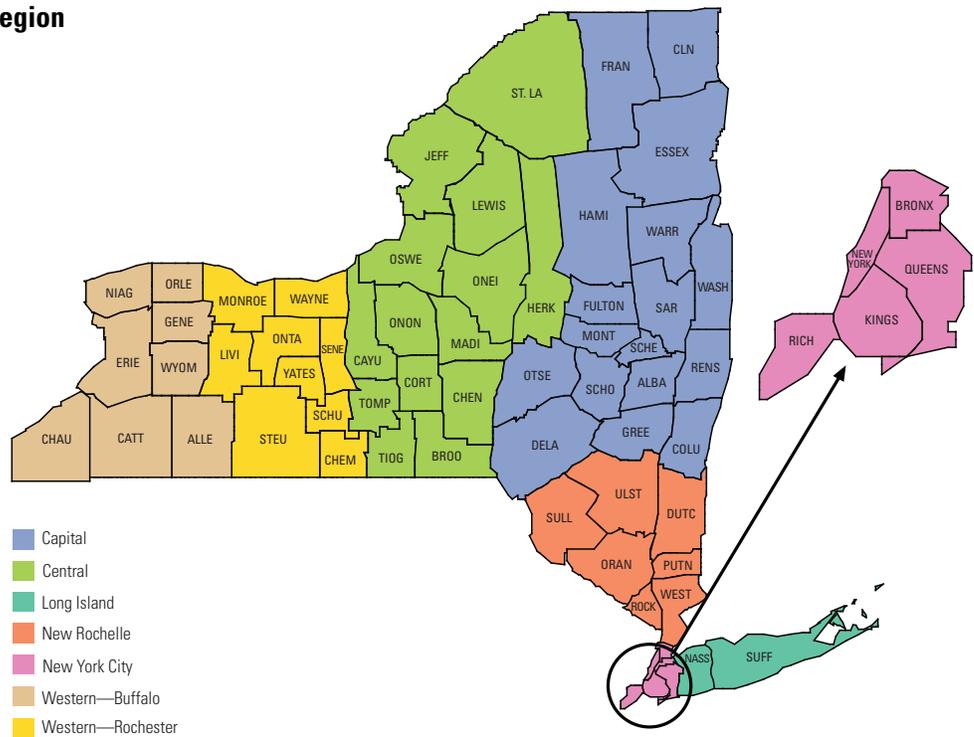
Source: For nursing homes, LTHHCP, and traditional personal care: UHF Analysis of Medicaid Reference Statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: September 2007 Medicaid statistics, SDOH.

Figure 1.5
Share of Medicaid Long-Term Care Program Spending in New York City, FFY 2007



Sources: For nursing homes, LTHHCP, and traditional personal care: UHF Analysis of Medicaid Reference Statistics, FFY 2005-2007 SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of SDOH Medicaid Managed Care Operating Report (MCOR) data, 12/31/07, provided by the MLTC/PACE Coalition.

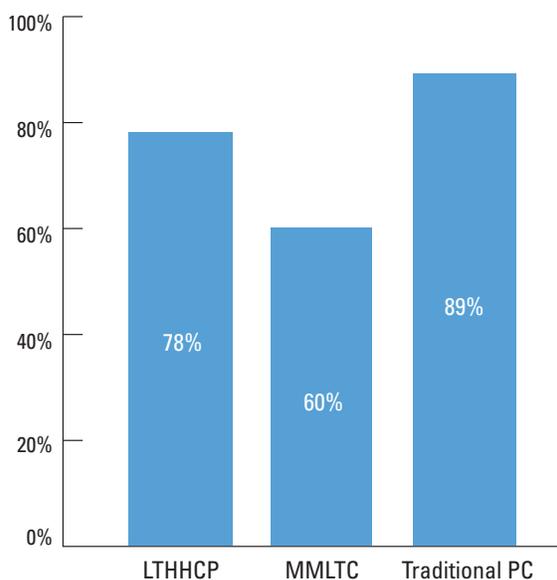
Figure 1.6
New York Counties, by Region



Source: Reprinted from the State Department of Health website: <http://nursinghomes.nyhealth.gov>.

Direct Care Service Spending: Most spending in community-based programs is attributable to direct care services.⁹ We were not able to obtain comparable data for nursing homes, but a significant proportion of the spending is attributable to direct care in that setting as well.

Figure 1.7
Share of Medicaid Long-Term Care Spending on Direct Care Services, by Community-Based Program



Sources: UHF analysis of September 2007 MARS data; NYS Managed LTC Plan Performance, CY 2005 (from American PACE Exchange); and Hokenstad 1995.

Note: Payment rates for direct care services in the LTHHCP include A&G (and care management) costs as well.

Program and Provider Capacity

As a matter of policy, the state does not restrict any of its long-term care programs geographically, and in practice most are available statewide. However, some program alternatives are not readily available everywhere in the state. For example, Medicaid managed long-term care is available primarily in New York City. Some rural counties (e.g., Chenango) have no LTHHCP provider or certified home health agency, and some (Schuyler, Madison) have extremely limited home care capacity.¹⁰

There has been a net reduction in long-term care capacity in the nursing home sector in recent years. Several factors have contributed to this reduction. First, an increasing portion of the state's nursing home beds are used to provide short-term care and post-acute

⁹ While the traditional personal care program provides only direct care services, approximately 11 percent of spending is for administrative costs, which includes quarterly nursing visits to supervise the direct care worker and review the plan of care.

¹⁰ Thomas Dennison, personal communication. See also: <http://homecare.nyhealth.gov/>.

rehabilitation (estimated at more than 13 percent in June 2008).¹¹ Additionally, following the recommendations of the New York State Commission on Health Care Facilities in the 21st Century, the state has eliminated nearly 1,100 beds and plans to eliminate another 1,600 by 2011.¹²

Provider Caseload Size: The size of individual providers within each program varies widely. For example, provider caseload size in the MMLTC program ranges from as few as 130 enrollees in some rural counties to as many as 5,900 in a single plan in New York City. In community-based programs, the average provider caseload in New York City is typically two to three times larger than that seen in the rest of the state.

Table 1.2
Average Provider Caseload Size, by Program, 2007

Medicaid LTC Program	Region	Number of Providers	Average Caseload Size	Range of Caseload Size
Nursing Homes	NYC	180	230	20 – 810
	Rest of State	469	150	20 – 630
	New York State	649	170	20 – 810
Traditional Personal Care	NYC	62	660	400 – 2,000
	Rest of State	153	110	n/a
	New York State	215	270	n/a
LTHHCP	NYC	29	350	20 – 2,570
	Both NYC and ROS	11	700	90 – 2,910
	Rest of State	69	100	10 – 490
	New York State	109	220	10 – 2,570
MMLTC	NYC	7	2,340	340 – 5,900
	Both NYC and ROS	1	420	n/a
	Rest of State	5	310	130 – 700
	New York State	13	1,410	130 – 5,900

Sources: Based on UHF analysis of SDOH Nursing Home Profile website, January 2008 Medicaid LTC reimbursement rate computation sheets for personal care (SDOH website), December 2008 NYC personal care vendor authorized caseload size (estimate from HRA), 2007 LTHHCP provider census, and September 2007 SDOH Monthly Medicaid Managed Care Enrollment Report.

Note: Average provider size for nursing homes was calculated for all residents in the home (beds in use), including non-Medicaid beneficiaries. Average caseload for personal care reflects authorized caseloads; we were unable to obtain actual enrollment by provider.

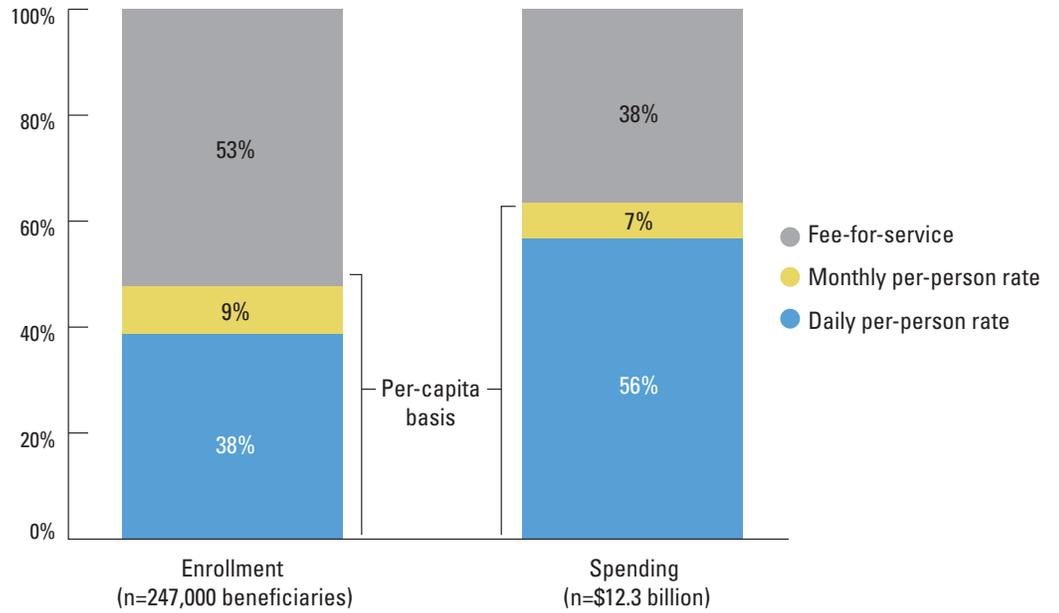
Provider Payment

More than half of Medicaid long-term care beneficiaries are enrolled in programs paid on a fee-for-service basis. The rest are enrolled in programs that are paid on a per-capita basis for each beneficiary enrolled.

¹¹ There were a total of 111,128 nursing home residents in June 2008. [Source: American Health Care Association, Health Services Research and Evaluation, analysis of CMS OSCAR Form 672.] Of these, 71 percent (79,031 residents) were Medicaid beneficiaries, 13 percent were Medicare beneficiaries, and 16 percent had other coverage or were paying privately.

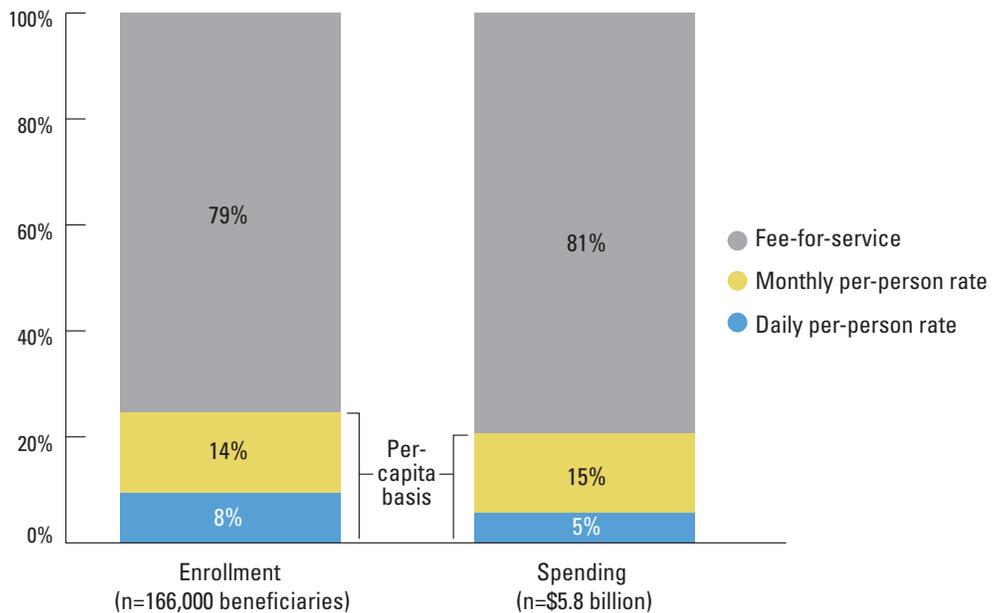
¹² <http://www.nyhealthcarecommission.org/>

Figure 1.8
Enrollment and Spending in All Medicaid Long-Term Care Programs, by Payment Type, 2007



Sources: UHF analysis of Sept 2007 MARS, FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF cost report.
 Note: Daily rate = nursing homes, ALP, and ADHC. Monthly rate = MMLTC and PACE. Fee-for-Service = PC, CHHA, LTHHCP, ADHC, consumer-directed PC, and TBI.
 Note: Percentages are rounded and may not sum to 100%.

Figure 1.9
Enrollment and Spending in Medicaid Community-Based Long-Term Care Programs, by Payment Type, 2007



Source: UHF analysis of Sept 2007 MARS, FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF cost report.
 Note: Daily Per-Person Rate = ADHC; Monthly Per-Person Rate = MMLTC and PACE; Fee-for-Service = PC, CHHA, consumer-directed PC, LTHHCP, and TBI.
 Note: Percentages are rounded and may not sum to 100%.

Looking only at community-based programs, those that are paid on a per-capita basis (Medicaid managed long-term care, adult day health care, and PACE) account for only 22 percent of community-based program enrollment.

Direct Care Workforce

All of the state’s long-term care programs provide direct care, here defined as assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). There is no single source of information about the workforce specific to the Medicaid program or to the beneficiary population examined in this report. For all populations and public payers (both Medicaid and Medicare), there are an estimated 100,000 certified nursing aides, 131,000 home health aides, and 60,000 personal care aides (including home attendants) employed in New York State.^{13, 14}

Job Titles and Training Requirements: New York’s Medicaid long-term care programs use a number of job titles to describe the workforce that provides direct care services: home attendant, personal care aide, home health aide, and certified nursing aide.¹⁵ Although there are modest differences in the range of tasks that direct care workers in these different titles can provide, and slightly different training requirements, the job responsibilities are essentially the same.¹⁶ For ease of discussion, the paraprofessionals performing these jobs are referred to collectively in this report as direct care workers.

Table 1.3
Direct Care Workforce Training Requirements

Medicaid LTC Program	Job Title	Hours of Training Required
Nursing Home	Certified Nursing Aide	100
Traditional Personal Care	Home Attendant	40
	Personal Care Aide	40
LTHHCP	Personal Care Aide	40
	Home Health Aide	75
MMLTC	Personal Care Aide	40
	Home Health Aide	75

Source: PHI.

Note: These are minimum state requirements; many providers provide additional on-the-job training.

¹³ PHI analysis of NYS Department of Labor statistics. Note that direct care worker employment in New York State is a rolling average of 2005 through 2007 and includes those working with: people with mental retardation or developmental disabilities, children, and people requiring short-term or post-acute care.

¹⁴ While the majority of home health aides, personal care aides, and home care aides are located in New York City, a much larger percentage of nursing aides and attendants are located elsewhere in the state.

¹⁵ Direct care services, also known as personal care services, are defined here as assistance with activities of daily living and instrumental activities of daily living.

¹⁶ The federal government requires 75 hours of certified nursing assistant (CNA) training. New York, like many other states, has additional requirements. As part of the required 100 hours, New York requires 30 hours of on-site clinical training in a nursing home facility.

Employment Arrangements and Worker Wages: Employment arrangements vary by region and program. Nursing homes directly employ most direct care workers as salaried staff. In New York City, traditional personal care program providers also directly employ direct care workers, while MMLTC and LTHHCP providers typically sub-contract with licensed home care service agencies (LHCSAs) for this service. In the rest of the state, it is more common for community-based program providers to employ their own workers, but a large proportion of direct care services are still provided through contractual arrangements with a LHCSA.

Workers in community settings are typically paid on an hourly basis. There is not a good source of statewide information about worker wages; however, in New York City, certified nursing aides and home attendants earn roughly \$13 and \$10 per hour, respectively. In contrast, home health aides earn roughly \$7 to \$8 per hour. The \$2 to \$3 per hour discrepancy between direct care worker wages in community-based settings is the result of the home attendant sector being unionized for more than 20 years with a master collective bargaining agreement administered by the Human Resources Administration, New York City's department of social services. Furthermore, the city's personal care program is governed by a living wage law that requires a \$10 minimum wage for agencies with city contracts. Home health aides have unionized more recently, and the living wage law does not apply to them because they do not work directly under a city government contract.

Turnover Rates: In 2007, the national annual turnover rate for direct care workers (certified nursing assistants) was roughly 66 percent, compared to 47 percent for New York State (American Health Care Association 2008). Again, there is no reliable source of information about turnover rates by region. However, workforce analysts report lower turnover in nursing homes in New York City than in those in other parts of the state, where the experience is more similar to the national average. There is also no definitive source of information about turnover rates for direct care workers in community-based settings at the national, state, or local level. National and local estimates range from 40 to 50 percent (Seavey et al. 2006). Workforce analysts report much higher turnover rates in New York City's home health aide workforce than in the city's home attendant workforce, which averages about 10 to 15 percent annually. They report rates comparable to or worse than the national average in other parts of the state. Lower turnover in New York City's personal care program and nursing homes is likely related to the previously mentioned labor-management agreements and living wage law mentioned above, and to more stability in obtaining full-time work.¹⁷

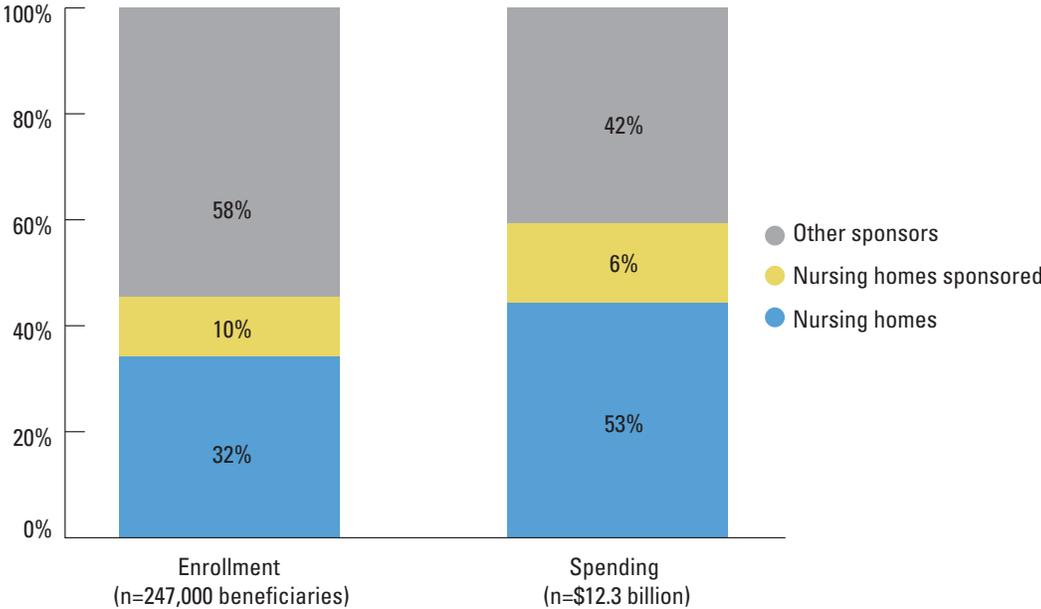
¹⁷ According to PHI (2008) the real median wage in 2006 for personal and home care aides in New York was \$8.03 per hour.

Training: Most basic training programs are sponsored by long-term care providers. There are 385 provider-sponsored training programs approved by the Department of Health to provide the basic training course for personal care aides and home health aides,¹⁸ and an additional 162 nursing-home sponsored programs that provide basic training for certified nursing aides.¹⁹ In New York City, the unions that represent the majority of direct care workers sponsor the 1199 SEIU Training Employment Fund and the Consortium for Worker Education, which also provide the basic training course. The State Department of Education approves additional training programs, such as those offered by Boards of Cooperative Educational Services, community colleges, and proprietary training schools.

Organizational Sponsorship

Some programs can only be offered by specific types of organizational sponsors. For example, LTHHCP providers may only be sponsored by a nursing home, hospital, or a community-based certified home health care agency.

Figure 1.10
Enrollment and Spending in Medicaid Long-Term Care Programs, by Organizational Sponsor, 2007



Sources: UHF analysis of Sept 2007 MARS data, FFY 2007 CMS-64, 2007 LTHHCP census, 2006 RHCF cost report, and September 2007 SDOH Medicaid managed care statistics.

Note: Percentages are rounded and may not sum to 100%.

¹⁸ Figures are as of April 2008 from SDOH, Home Health Aide Training Programs, All Programs: Open and Closed, posted to the Health Provider Network.

¹⁹ An additional 200 proprietary and other programs train certified nursing assistants as well. The department of health does not approve these programs; they are approved by the education department.

However, it is not uncommon for a single organization to sponsor more than one kind of long-term care program. In terms of both enrollment and total spending, the nursing home sector is the largest organizational sponsor of long-term care programs. They account for an estimated 42 percent of long-term care beneficiary enrollment and 59 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities.

Rules, Regulations, and Administrative Structure

A basic understanding of the rules that govern service delivery and the differences between the various long-term care programs provides an important context for understanding why the state’s long-term care system looks the way it does today, and how it might be improved. The state’s long-term care programs vary in terms of eligibility, covered services, enrollment procedures, payment methodology, and regulatory requirements.

Federal Coverage Requirements

As a condition of receiving federal matching funds for their Medicaid programs, all states are required to follow rules established by the federal government.²⁰ Some of these rules apply to all states; others are proposed by individual states and approved (or rejected) by CMS. The results of these compulsory rules and negotiated agreements are the official operating rules for state Medicaid programs; they are commonly referred to as the State Medicaid Plan.

Federal Coverage Requirements for New York State Medicaid Long-Term Care Programs

<p>“Entitlement Programs”</p> <p>Mandatory Nursing Homes Certified Home Health Agency</p> <p>Optional Traditional Personal Care Consumer-Directed Personal Care Medical Adult Day Health Care Medicaid Assisted Living Program</p>	<p>1915(c) Waiver Programs Long-Term Home Health Care Program Traumatic Brain Injury (TBI) Waiver Nursing Home Transition and Diversion Waiver</p>
	<p>Managed Care Programs Medicaid Managed Long-Term Care Program of All-Inclusive Care for the Elderly Medicaid Advantage Plus</p>

²⁰ Revenue from the federal government accounts for approximately half of all Medicaid spending in New York. For more information, see Birnbaum 2008.

The federal government requires states to provide some long-term care services (mandatory services) and gives them the option to cover others (optional services). These mandatory and optional state plan services, which must be made available to all individuals who meet statewide eligibility requirements, are sometimes referred to as “entitlements” because of their specific protections under federal law. In contrast, the federal government also allows states to provide long-term care to specific populations through 1915(c) waivers and managed care plans, but it gives them much more latitude to establish eligibility criteria.

Mandatory and Optional State Plan Services: Like all states, New York is required to provide nursing home care and home health care, also known as certified home health agency (CHHA) services. Like 33 other states,²¹ New York provides personal care as an optional state plan service, and does so in two ways: as traditional personal care (services provided by an agency) and as consumer-directed personal assistance (services provided by an individual hired and supervised directly by the beneficiary or their surrogate).²² The state has also opted to provide medical adult day health care services.

1915(c) Waiver Programs: New York, like all other states (except Arizona), has also chosen to provide long-term care through 1915(c) waiver programs. Section 1915(c) of the federal Social Security Act allows states to request a waiver of certain federal Medicaid requirements in order to establish community-based programs for specific target populations, such as frail seniors with nursing home level of care needs (defined below, in the Eligibility section). States have the authority to limit enrollment in these “waiver” programs by age, geographic region, or type of disability; there is no limit on the number of 1915(c) waiver programs a state can operate (Kitchener et al. 2005). New York has nine long-term care waiver programs that provide mandatory and optional state plan services (home health care and personal care) together with services not typically provided by Medicaid (called “waiver services”), such as home modification and meals on wheels. They also provide care management or service coordination. Only three of the nine programs primarily serve frail seniors and adults with physical disabilities: the Traumatic Brain Injury waiver program (TBI); the Nursing Home Transition and Diversion Waiver (NHTDW); and the Long-Term Home Health Care Program (LTHHCP), which is by far the largest. Federal approval to operate waiver programs must be reauthorized every five years.²³

²¹ Kaiser Family Foundation, www.statehealthfacts.org.

²² For ease of discussion, the consumer-directed personal assistance program is referred to here as the consumer-directed PC program.

²³ Initial 1915(c) waivers are approved for a three-year period.

Managed Care: The federal government also allows states to provide long-term care services through managed care plans. New York provides long-term care services through three kinds of managed care arrangements — Medicaid managed long-term care (MMLTC), the Program of All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus.²⁴ All three programs provide mandatory and optional state plan services (such as home health care, personal care, adult day health care, nursing home care, and preventive health care services such as dentistry and podiatry) and “waiver” services. They also provide care management services but have a broader scope of responsibility than waiver programs. They are responsible for managing the totality of beneficiaries’ health, mental health, and long-term care needs. The primary difference between the three programs is in how they are financed. MMLTC is financed exclusively by Medicaid, whereas PACE and Medicaid Advantage Plus are financed by both Medicaid and Medicare. As a result, PACE and Medicaid Advantage Plus provide (and pay for) Medicare covered services, such as primary and acute care. MMLTC is required to coordinate these services but does pay for them.

Geographic Availability and Choice: All 12 of the state’s long-term care programs are available statewide; New York does not restrict any of them to specific areas. In addition, enrollment in all programs is voluntary; New York does not mandate that beneficiaries access long-term care through any one particular program.²⁵

The Significance of Entitlement Programs

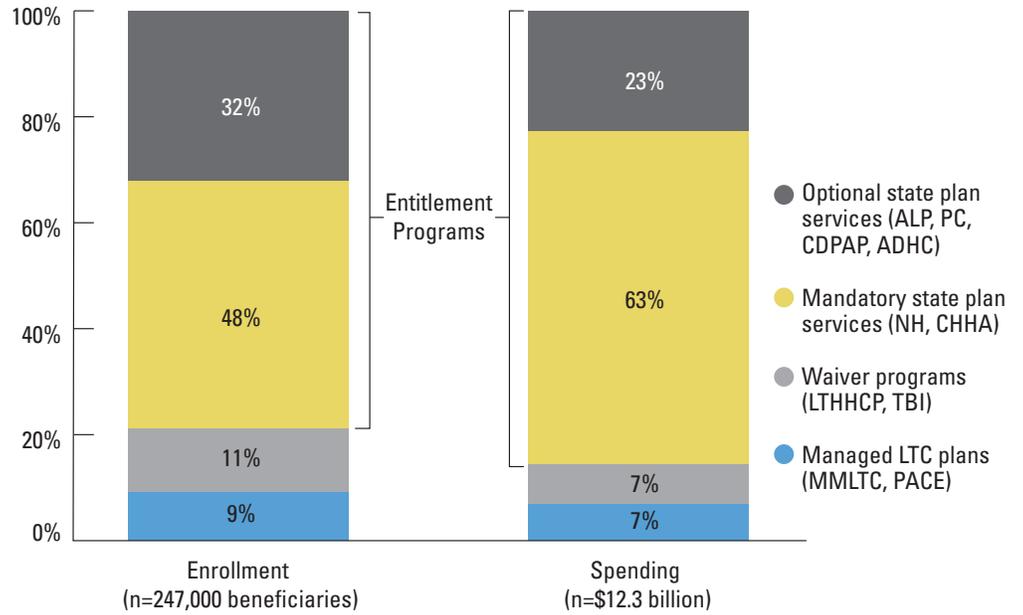
In contrast to some states that provide long-term care services exclusively through 1915(c) waiver programs (many of which have waiting lists), New York provides long-term care services primarily through its mandatory and optional state plan service “programs.” States are not permitted to maintain waiting lists for the services accessed through these programs.

Eighty percent of New York’s beneficiaries access long-term care through an “entitlement” program; associated spending accounts for 86 percent of Medicaid long-term care spending. Beneficiaries enrolled in waiver programs and managed long-term care plans account for 20 percent of all long-term care beneficiary enrollments; associated spending accounts for 14 percent of long-term care spending.

²⁴ In terms of federal coverage requirements, PACE is technically a state plan optional service.

²⁵ New York does require, however, that dually eligible beneficiaries (those who have both Medicaid and Medicare coverage) who are enrolled in a Medicare Advantage plan (Medicare HMO) receive Medicaid long-term care services through a Medicaid Advantage Plus plan sponsored by the same organization if it offers one.

Figure 1.11
Enrollment and Spending in Medicaid Long-Term Care Programs, by Federal Coverage Distinction, 2007



Sources: UHF analysis of Sept 2007 MARS , FFY 2007 CMS-64, 2007 LTHHCP census, and 2006 RHCF4 cost report.

Covered Services

Each of the state’s long-term care programs provides a distinct assortment of services. The services provided by the four programs described in this report are outlined below.

Direct Care: All of the state’s long-term care programs provide assistance with activities of daily living (ADLs), such as bathing and toileting, and instrumental activities of daily living (IADLs), such as meal preparation and housekeeping. However, each program uses different terminology to describe this type of care. For ease of discussion, these services are referred to as direct care in this report. See the Glossary for additional detail.

Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs)

ADLs:

- Feeding
- Toileting
- Bathing
- Transferring/Mobility
- Dressing/Grooming

IADLs:

- Household Chores
- Meal Preparation/Shopping
- Escort/Errands

Care Management: Three of the four programs (nursing homes, LTHHCP, and MMLTC) provide care management services, typically provided by nurses who are directly employed by the provider and sometimes by social workers.²⁶ While the purpose of care management is to coordinate care, the scope of care management responsibilities is not well defined. As a result, it varies among the programs, as well as among providers within the same program.²⁷

Skilled Nursing and Therapies: Three of the four programs (nursing homes, LTHHCP, and MMLTC) provide skilled nursing services, physical therapy, speech therapy, and occupational therapy. However, because home health care (which includes skilled nursing and therapies) is a federally mandated service, traditional personal care program beneficiaries are not prohibited from accessing these services directly from a certified home health agency.

Waiver Services: Two of the four programs (LTHHCP and MMLTC) provide “waiver” services, such as home modification and meals on wheels. Waiver services are services that are not typically covered by Medicaid but are available to specific populations through 1915(c) “waiver” programs. The different programs (and individual providers within each program) provide slightly different sets of waiver services.

Nursing Home Care: Two of the four programs (nursing homes and MMLTC) provide nursing home care. Although current long-stay nursing home residents are not eligible to enroll in MMLTC, individuals who come to need this service after a period of enrollment are eligible to receive it and have it paid for by MMLTC; beneficiaries do not have to disenroll from MMLTC, and can continue to receive care coordination services from the MMLTC while receiving nursing home care. In contrast, beneficiaries in the LTHHCP or the traditional personal care program must disenroll from these programs in order to receive Medicaid long-stay nursing home care.

Preventive Care: Two of the four programs (nursing homes and MMLTC) are responsible for providing preventive care services, such as dentistry, optometry, and podiatry. However, because preventive care services are also Medicaid State Plan services, beneficiaries enrolled in the LTHHCP and traditional personal care programs are not prohibited from accessing them independently.

²⁶ PACE and Medicaid Advantage Plus plans also provide care management services.

²⁷ Care management is distinct from service coordination, a covered service in several of the smaller 1915(c) waiver programs (TBI, NHTDW). In these programs, service coordination is separated completely from the delivery of other services; one organization coordinates the plan of care, and one or more other organizations provide direct care and other specified services.

**Table 1.4
Covered Services, by Program**

	Traditional PC	LTHHCP	MMLTC	Nursing Homes
Direct Care (home attendant, home health aide, personal care aide, or certified nursing aide)	X	X	X	X
Care Management Services (provided by a nurse and/or social worker)		X	X	X
Skilled Nursing and Therapies (physical therapy, occupational therapy, speech pathology)		X	X	X
“Waiver” Services (such as meals on wheels, home modifications, and respite care)	N/A	X	X	N/A
Nursing Home Care			X	X
Preventive Care (dentistry, optometry, podiatry, prostheses and orthotics, etc.)			X	X

List of covered services according to CMS and New York State Department of Health websites: <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp> and http://www.health.state.ny.us/facilities/long_term_care/.

Eligibility — Medical and Financial

Within federal guidelines, states have considerable latitude to establish eligibility rules for Medicaid long-term care services. In all states, beneficiaries must demonstrate both financial and medical need. Compared to other states, New York has fairly generous eligibility criteria.^{28, 29}

Medical (Functional) Eligibility Criteria

For all long-term care programs (except certified home health agencies), applicants must demonstrate that they need help in order to perform direct care tasks.³⁰ The need for assistance must result from a functional, cognitive, or medical impairment.

Nursing Home Level of Care: Eligibility for eight of the 12 long-term care programs is restricted to beneficiaries who require a level of care available in a nursing home. Each of the state’s long-term care programs uses a different assessment tool — and therefore slightly different criteria — to determine level of need. As a result, there is not a consistent definition of nursing home level of care across programs. The criteria always include an evaluation of functional capacity, cognitive status, health conditions, and clinical care needs.

²⁸ Medicaid Reference Guide: http://www.health.state.ny.us/health_care/medicaid/reference/mrg/.

²⁹ For more information on Medicaid long-term care program eligibility, see Bogart 2007.

³⁰ The medical criterion for CHHA services is the need for “skilled care,” services typically provided by a specific type of professional — e.g., a nurse, physical therapist, or speech therapist. Also, eligibility to receive housekeeping services through the Personal Care program technically requires that an individual requires help with only IADLs, such as shopping, meal preparation, and housekeeping. Research suggests that most beneficiaries also need assistance with ADLs.

Medicaid Long-Term Care Programs by Nursing Home Level of Care Eligibility Requirement

NH Level of Care Required	NH Level of Care Not Required
Nursing Homes	Traditional Personal Care
Long-Term Home Health Care Program	Consumer-Directed Personal Assistance Program
Medicaid Managed Long-Term Care	Certified Home Health Agency Services
Medicaid Assisted Living Program	Medical Adult Day Health Care
Program of All-Inclusive Care for the Elderly	
Traumatic Brain Injury Waiver	
Nursing Home Transition and Diversion Waiver	
Medicaid Advantage Plus	

General Financial Eligibility Criteria

To be eligible for Medicaid long-term care, applicants must first meet general Medicaid eligibility rules. New York’s Medicaid state plan covers individuals with incomes up to the equivalent of approximately 80 percent of the federal poverty limit (\$8,700 annually), and limits assets to \$13,050 in savings. For long-term care, there is an additional limit on assets — beneficiaries cannot have home equity valued at more than \$750,000.

Table 1.5
Medicaid Eligibility: Income and Resource Levels, 2008

	Income Levels		Asset Levels
	Monthly	Annually	
Medicaid Eligibility Levels	\$725	\$8,700	\$13,050
Spousal Support and Resource Level	\$2,610	\$31,320	\$74,820 – \$104,400

Source: http://www.nyc.gov/html/hra/downloads/pdf/income_level.pdf.

Medically Needy Program: Higher-income applicants with high medical expenses may still qualify for Medicaid through the Medically Needy Program (commonly called the “spend-down” program). New York, like many other states, allows applicants with excess income attributable to medical expenses to “spend down” to the financial resource limit in order to qualify for Medicaid. In New York in 2008, “excess income” was the amount of monthly income above \$725 attributable to medical expenses. For example, a man who routinely spends \$25 a month on an over-the-counter medication would still qualify for Medicaid if his income was \$750. Beneficiaries are required to document medical expenses above the income threshold in order to maintain eligibility.

The Medically Needy program plays an important role in access to long-term care. In 2003, one-quarter of all the state's Medicaid enrollees qualified through the Medically Needy program. This trend was consistent for all Medicaid eligibility categories except the elderly; more than 70 percent of seniors who qualified for Medicaid did so through this program.³¹

LTC-Specific Financial Eligibility Criteria

Some financial eligibility criteria, such as the limit on the value of home equity, are unique to long-term care beneficiaries; other rules are unique to individual programs. For example, nursing homes have more stringent requirements than community-based programs, but they also have specific protections for beneficiaries' spouses.

Transfer of Assets: Financial eligibility for nursing home care is subject to a retrospective review of assets (also called a look-back period) and is subject to financial penalties. For example, an applicant is subject to a penalty period if he or she has transferred assets (such as by making gifts to children or grandchildren) within the three years before applying for Medicaid. During the penalty period, he or she is ineligible to receive Medicaid-covered services. As a result of the federal Deficit Reduction Act of 2005, this federally mandated look-back period for nursing home care is being gradually extended from 36 to 60 months; expansion began in February 2009. New York does not require a financial look-back period for any other Medicaid long-term care program.

Spousal Resource Protections: Federal law also mandates income and asset thresholds for the spouses of nursing home residents ("community spouses") to ensure that they are not forced into poverty as a result of their wife or husband receiving long-term care; New York has traditionally granted the maximum spousal resource protections allowable under federal law (\$31,320 in income and \$104,400 in assets in 2008). New York currently provides comparable resource protections for spouses of beneficiaries enrolled in the Long-Term Home Health Care Program, as discussed in Chapter 4 of this report, but not for those enrolled in its two other 1915(c) waiver programs for these populations, TBI and NHTDW. There are no specific spousal resource protections for other long-term care programs.

³¹ UHF analysis of SDOH website, CY 2003 Medicaid eligibility statistics, and Kaiser State Health Facts website, Medicaid medically needy statistics.

Spousal Refusal: New York also extends the spousal refusal provision, which is federally mandated for nursing home care, to its other long-term care programs. The provision protects the right of a Medicaid beneficiary’s spouse to remove his or her income or assets from the financial eligibility determination. (The state has the right to appeal when it believes the spouse has sufficient means to pay.) In programs that do not have specific spousal resource protections, the spousal refusal provision serves the same effective policy purpose — it helps ensure that spouses are not forced into poverty as a condition of their wife or husband receiving long-term care.

**Table 1.6
Medicaid Financial Eligibility Rules Specific to Long-Term Care**

Medicaid LTC Program	Transfer of Asset Penalty	Spousal Resource Protections	Spousal Refusal	Home Equity Limit
Nursing Home	X	X	X	X
Traditional PC			X	X
LTHHCP		X	X	X
MMLTC			X	X

Administration of Medicaid Determination

As it does for general Medicaid, county government is responsible for determining Medicaid financial eligibility for long-term care, on behalf of the State Department of Health (SDOH). Counties are required to make the initial determination of financial and medical eligibility within 45 days of application, and are then responsible for reauthorizing Medicaid eligibility every 12 months.³²

Fair Hearings and Appeal Rights: Federal law requires that Medicaid eligibility be determined within 45 days, unless there is the need to establish disability status for the purposes of Supplemental Security Income (SSI) determination, in which case eligibility must be completed within 90 days. All Medicaid beneficiaries have the right to a fair hearing if they are deemed ineligible for services or receive fewer hours of service than they believe they need.

³² When retroactive coverage is appropriate, a case may be authorized for up to 15 months — 3 months retroactively and 12 months prospectively.

Access

Most beneficiaries access Medicaid long-term care services directly from a hospital following a crisis resulting from a sudden or dramatic health care event, such as a stroke or a fall. With the exception of the personal care program, beneficiaries typically enroll with the help of an individual program provider (a nursing home, LTHHCP provider, or MMLTC plan) who is then the service provider. Applicants to the personal care program, on the other hand, apply directly to their local department of social services office.

Information on Program and Providers: The SDOH website provides general information about Medicaid long-term care programs, services available, and how to access them. There is variation in how much additional information individual counties provide. The state is in the midst of implementing NY Connects, an initiative at the county level that will establish central points of information about long-term care services. As of January 2009, NY Connects programs were in operation in 47 of the state's 62 counties.³³

Information about program-specific provider performance is available to the public on the federal CMS Home Health Compare and Nursing Home Compare websites and on the SDOH Home Health Profile (launched in March 2008) and Nursing Home Profile websites. There are concerns about the limitations of the publicly reported quality measures for the purpose of helping beneficiaries choose providers.³⁴

Provider Requirements

The State Department of Health is responsible for determining service capacity. The size of some programs is controlled through the certificate of need process. For example, new nursing homes and LTHHCP providers, as well as nursing home beds and LTHHCP slots, must be pre-approved by the State Hospital Review and Planning Council, which generally approves recommendations advanced by the SDOH. New providers and provider size in the personal care program are determined by the local department of social services (on behalf of SDOH). New MMLTC plans (and Medicaid Advantage Plus plans) must be approved by both the SDOH and the State Department of Insurance. There is no limit on the size of individual plans.

³³ As of January 2009, NY Connects was not available in the following counties: Chenango, Columbia, Hamilton, Livingston, Madison, Oswego, Rensselaer, Seneca, Suffolk, Warren; and the five counties of New York City. See www.nyconnects.org.

³⁴ Because the state requires LTHHCP providers to adhere to the Medicare conditions of participation, the federal government includes them in its national evaluation of CHHA performance. This inclusion may unintentionally misrepresent their performance on key measures of emergent care use and hospitalizations because the LTHHCP beneficiary population is more chronically disabled, and the duration of care is much longer, than that of the typical CHHA Medicare beneficiary.

Payment

Personal care and LTHHCP providers are paid for the number of hours or visits they provide (fee-for-service). Nursing homes receive a daily rate and MMLTC plans receive a monthly rate for each beneficiary they enroll. Nursing home rates are risk-adjusted to account for higher resource requirements for frailer residents; MMLTC rates are not risk-adjusted. The State Department of Health is responsible for fiscal monitoring. Providers are required

Table 1.7
Summary of Medicaid Payment Methods, by Program

Medicaid LTC Program	Payment Method	Risk-Adjusted
Nursing Home	Per person per day	Yes
Traditional PC	Fee-for-service	N/A
LTHHCP	Fee-for-service	N/A
MMLTC	Per person per month	No

to submit cost reports detailing their expenditures at least once a year. Financial penalties or suspension of enrollment privileges may be assessed if spending on individual services or administrative and general (A&G) costs are exceeded. There is no publicly reported information about provider financial performance.

Quality Monitoring

The State Department of Health has oversight responsibility for the state's 12 long-term care programs. Responsibility for the majority of programs has recently been consolidated within a newly created division, the Office of Long-Term Care, while responsibility for the MMLTC program remains located in a bureau within the Office of Health Insurance Programs. Both offices report directly to the Commissioner of Health.

The state's primary vehicle for evaluating quality of care is the on-site performance review (survey process). SDOH regional offices are responsible for conducting performance reviews; the frequency of these reviews ranges from at least once every 12 months to once every 36 months for the various programs. The SDOH is also responsible for monitoring the performance of the local departments of social services, which in turn are responsible for monitoring the performance of personal care and LTHHCP providers. CMS, under the auspices of its regulatory responsibility for the Medicare program, evaluates quality outcomes in three of the state's programs — nursing homes, LTHHCP providers, and certified home health agencies.

Policy Implications

New York's Medicaid program plays a fundamental role in meeting the long-term care needs of the estimated 247,000 individuals enrolled in one of the state's 12 long-term care programs that primarily enroll frail seniors and adults with physical disabilities each month. The state's Medicaid program now faces heightened fiscal pressures and demographic realities. This section of the report highlights current and future challenges, and identifies nine critical issues for further research and discussion. These issues are further explored in the accompanying program portraits, which provide a more in-depth look at four of the largest long-term care programs: nursing homes, personal care, the Long-Term Home Health Care Program, and Medicaid managed long-term care.

Critical Issues for System Redesign

Information and Guidance at Points of Entry
System Simplification
Consistent Service Determinations
Adequate Provider Capacity
Effective Care Management
Integration of Medicaid and Medicare Financing
Payment Methodologies
Direct Care Workforce: Paid and Family Care
Regulation, Oversight, and Quality Improvement

In exploring these interrelated critical issues, it may be helpful to keep three general principles in mind:

- *Focus on people, not programs.* While it is essential to build on existing capacity, solutions should be appropriate to the needs of individuals and their caregivers. They should not merely preserve specific programs or individual providers.
- *Concentrate on systemic, not program-specific, reforms.* A change in one of the state's Medicaid-financed long-term care programs will affect access, cost, and quality in the rest. Thus, reform strategies should be systemic, not restricted to one program in isolation from the others.

- *Contemplate regional, not statewide, service delivery solutions.* Regional differences in access to care and service utilization suggest the need for more uniform implementation of policies and regulations. At the same time, solutions to questions about how to organize and finance service delivery must be flexible in order to capitalize on existing capacity and respond to varying regional circumstances.

Critical Issues

Information and Guidance at Points of Entry

Many people access long-term care services for the first time from a hospital or certified home health agency at a moment of crisis, necessitating quick and often difficult decisions. Some states have centralized access to Medicaid long-term care services through a single organizational gateway (often called a “single point of entry”). This is not the case in New York, where beneficiaries frequently seek services from an individual provider (e.g., a nursing home or Medicaid managed long-term care plan) that then becomes their service provider. These initial decisions can have a lasting impact, as the service provider selected often continues to provide services over the long term. In the current system, there is wide variation in how much information and support is currently provided by counties and other common points of entry.

There is consensus that a reform agenda for New York State should include a strategy for providing more timely information and guidance at points of entry and transition. However, there is disagreement about how best to accomplish this: by consolidating access to all long-term care services through one designated local entity (the single point of entry approach) or by building capacity into pathways that already exist, such as hospitals and certified home health agencies. Given regional differences that may favor one solution over the other, it is conceivable that there might be different approaches in different parts of the state.

Regardless of the path (or paths) New York pursues, it will be important to clearly define expectations about what entry points into the long-term care system should be designed to accomplish and for whom. Responsibilities range from providing useful information (the goal of NY Connects) to actively helping beneficiaries plan for and secure services, which would involve more comprehensive needs assessments and options counseling. There are choices to be made about how to deliver and pay for these critical functions — for example, should they be provided individually or bundled? Should they be made available to all residents or only to Medicaid-eligible beneficiaries? Unsurprisingly, the thorniest issue is how a reorganized entry system would be financed, as any approach will require additional resources: for hiring and training qualified personnel, for ensuring that the available information stays current, and for implementing information technology for efficient data exchange.

System Simplification

New York’s Medicaid long-term care system is complex, serving a large population with diverse needs. Providing long-term care through 12 distinct programs supports the principle of choice by offering beneficiaries meaningful options. On the other hand, this array of programs adds complexity that runs counter to other policy goals — effective government oversight, provider efficiency, continuity of care, and cost-effectiveness. An important goal of system reform is to identify opportunities to simplify the long-term care system in ways that make it easier for beneficiaries and providers to understand and more manageable for government to regulate.

It is difficult to distinguish among the three community-based programs explored in this report — traditional personal care, the Long-Term Home Health Care Program, and Medicaid managed long-term care. They serve similar populations and most spending is attributable to direct care services. The LTHHCP and MMLTC provide care management and a broader array of services than the personal care program does, but the primary difference among the three programs is in how they are paid. The personal care program and LTHHCP providers are paid on a fee-for-service basis. In addition, the LTHHCP limits how much can be spent on each beneficiary to 75 percent of the average Medicaid nursing home rate in the same county.³⁵ In practical terms, this means that beneficiaries in New York City who require more than 36 hours of direct care per week are not able to enroll in the LTHHCP. (As a point of reference, approximately 60 percent of New York City’s personal care program beneficiaries receive 36 or more hours of direct care per week.)

³⁵ There are some exceptions to this requirement. See Chapter 4.

MMLTC plans receive a monthly premium for each beneficiary they enroll; however, these premiums are not risk-adjusted. Therefore, plans may not have sufficient financial incentive or resources to enroll people with the most intensive direct care needs. As a result, some of these high-need individuals are enrolled in the personal care program. One of the most troubling aspects of the current long-term care system is the large number of beneficiaries in New York City who have nursing home level of care needs yet are enrolled in the personal care program. Many of these beneficiaries would likely benefit from care management and additional services that the MMLTC and the LTHHCP provide but that the personal care program does not.

A reform strategy must take a closer look at the population with nursing home level of care needs. Are they receiving the right care, in the right setting, at the right price? Given apparent overlap in target populations, it will be important to decide whether to maintain both LTHHCP and MMLTC programs as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. Solutions must reflect regional differences. For instance, the LTHHCP plays a particularly significant role outside New York City. If the state opts to consolidate programs, it will likely need a different strategy for counties where the LTHHCP is the primary way for beneficiaries to receive community-based long-term care.

Consistent Service Determinations

Regional differences in enrollment, service utilization, and spending result, in part, from differences in the way local districts interpret state policies, such as health and safety regulations and level of need determinations. A stark example of such regional inconsistency may be seen in the personal care program: 24 percent of personal care program beneficiaries in New York City receive 12 to 24 hours of direct care per day, while this level of service is rarely found elsewhere in the state. In all likelihood, people outside New York City who require 24-hour care seven days a week, but do not have family members available to provide that much help, would receive care in nursing homes. A reform strategy should explore opportunities to achieve more consistent implementation of policies and regulations, including more specific guidelines about the roles and expectations of family caregivers.

The use of a different assessment tool in each program probably contributes to this variation. The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives, including: a consistent definition of nursing home level of care; a standard basis for determining what resources are required to address a beneficiary's needs; and a more robust evaluation of quality outcomes across programs and settings. Because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high priority and garnering sufficient resources and stakeholder cooperation.

Adequate Provider Capacity

Regional differences in enrollment, service utilization, and spending also result from geographic variation in provider capacity. For example, in some rural counties there is no longer an LTHHCP provider or a certified home health agency, and in others access to direct care services is extremely limited. System redesign will require important decisions about where additional capacity and capital improvement projects are warranted, and how to finance them efficiently. These decisions would be informed by a needs methodology that can accurately project future needs and criteria to guide decisions about where the investments should be made.

In the current system, most providers have relatively small caseloads. Because they do not benefit from economies of scale, smaller organizations may struggle to remain financially viable, keep pace with technological advances, and provide clinical specialization. Smaller programs are also more vulnerable to the effects of the recent workforce shortages and rising transportation costs that have had a serious impact on access to services in some parts of the state. Better information would help assess where and to what extent smaller programs are needed to accommodate the needs of beneficiaries who live in rural or semi-rural areas, and where cost efficiencies could be achieved through provider consolidation without diminishing access to appropriate care.

Effective Care Management

Effective care management for people with multiple chronic health conditions helps prevent avoidable events, such as medication errors or urinary tract infections; promotes early treatment to slow functional and cognitive decline; and fosters more effective disease management, such as better glucose monitoring for diabetics. In order to address the full complement of beneficiaries' needs, it will be important to implement strategies that more fully integrate long-term care with the delivery of medical, mental health, and social services. However, many factors make it difficult to provide care management that effectively balances cost and quality: a shortage of nurses and social workers with the required skills and experience; regulatory requirements whose documentation consumes a substantial amount of the time available to manage beneficiary care; differences in how providers interpret the scope of their care management responsibilities; and gaps in the availability of local services, such as transportation and in-home mental health care.

In the current system, care management is not consistently available where it is most needed. Some programs provide it; others do not. There is a need for more explicit criteria to guide decisions about who should receive care management and a routine process for identifying them, such as screening at points of entry and transition. A reform strategy also needs to determine if care management is mandatory for these individuals, or whether it should remain available only through designated programs (such as the LTHHCP and MMLTC). A reform agenda must also include a strategy for regularly monitoring and evaluating the effectiveness of care management, and for ensuring that professionals who perform this role have appropriate skills, training, and supervision.

More research would help determine which of the state's program models are most successful at managing care for different populations, and how much they cost. Such research could inform both policy decisions about where additional capacity is needed, and beneficiary decisions about which program (or combination of services) is most appropriate.

Integration of Medicaid and Medicare Financing

Because most long-term care beneficiaries have multiple chronic medical conditions, they typically use a lot of medical services. For dually eligible beneficiaries (those with both Medicaid and Medicare coverage), acute care is paid for primarily by Medicare. Medicaid pays for long-term care services, but the substantial and more immediate savings that result from effective long-term care (e.g., avoiding costly hospitalizations) accrue primarily to Medicare, not Medicaid.

There is continuing interest at both the state and federal level in more fully integrating Medicare and Medicaid financing at the provider or plan level. The Program of All-Inclusive Care for the Elderly (PACE) is widely cited as a successful model of integrated financing and service delivery, but replicating the program (as currently configured) on a broad scale has been slow.³⁶ In contrast, the state's MMLTC plans have grown fairly rapidly, but MMLTC does not receive Medicare financing. To foster more service delivery integration and capture savings that accrue from effective long-term care, the State Department of Health now requires sponsors of new MMLTC plans to offer Medicare Special Needs Plans (SNPs);³⁷ in addition, the Department of Health recently established a new program, Medicaid Advantage Plus.³⁸

Most MMLTC plans are currently sponsored by provider-based organizations. The new SNP requirement for future MMLTC sponsors and requirements for the new Medicaid Advantage Plus program both suggest the need for large organizational sponsors, such as insurance companies, that can assume the financial risks associated with providing both long-term and acute care. It may be difficult for provider-based organizations to meet these new requirements. Strategies to more fully integrate Medicare and Medicaid financing will need to consider how best to build on and incorporate the capacity and expertise of current long-term care providers.

³⁶ PACE represents a very small share of long-term care enrollment and spending, with slightly more than 3,000 enrolled in September 2007. Providers receive prospective reimbursement from both Medicare and Medicaid and are responsible for all health care as well as long-term care services. The fiscal and regulatory requirements for PACE, such as the capital costs associated with building the required adult day health care system, restrict the number of community providers that can become plans (Hokenstad and Haslanger 2004).

³⁷ A special needs plan (SNP) is a type of Medicare Advantage coordinated care plan that is designed specifically for beneficiaries with special needs, including institutional residents, dually eligible individuals, and people with severe or disabling chronic conditions. In 2008, there were 26 SNPs offered in New York; enrollment in the plans is optional. (Medicare Advantage is a more generic Medicare managed care plan available to all Medicare beneficiaries, regardless of their level of disability.) See Glossary.

³⁸ Medicaid Advantage Plus is a managed care option for dually eligible individuals over the age of 18 with nursing home level of care needs. Beneficiaries must enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product, which also covers long-term care services. Enrollment in the plans is optional.

Payment Methodologies

The state's nursing homes are paid a daily rate per person that is risk-adjusted to account for the additional resources associated with caring for individuals with more extensive needs.

In community-based settings, the vast majority of beneficiaries are enrolled in programs that are paid on a fee-for-service basis. For these providers, revenue is directly related to units of service provided: more units mean more income. The remaining beneficiaries are enrolled in MMLTC and PACE plans, which receive per-capita payment; however, this payment is not risk-adjusted. In practical terms, unadjusted capitation means that plans may not have sufficient financial incentive or resources to enroll beneficiaries who are especially frail or have complex medical conditions. This situation has the potential to disrupt continuity of care if plans disenroll individuals whose care needs become too costly.

A reform agenda should consider a methodology for risk-adjusting Medicaid payment for MMLTC and PACE plans. More research is needed to address the many outstanding questions about how best to do this. For example, additional research is needed to determine the extent to which different payment methodologies achieve different results. Such analysis would help inform decisions about whether to risk-adjust payments in other programs that have traditionally been paid on a fee-for-service basis, such as the LTHHCP.

Regardless of how payment is structured, reform discussions should consider the extent to which underlying financial incentives affect current providers' ability and capacity to change. For example, the LTHHCP is widely believed to subsidize the operation of nursing homes, and payment for direct care services in CHHAs and LTHHCP providers is widely believed to subsidize professional staff salaries and other mandates. Such cross-subsidization is not necessarily bad, but it does make it difficult to identify what Medicaid is paying for and at what price—and it may provide strong motivation for key parties to resist changing the way services are organized and financed.

Direct Care Workforce: Paid and Family Care

Direct care services account for a substantial share of service utilization and spending in all settings (PHI 2008). While technological innovations — such as telehealth monitoring of blood pressure — can make service delivery more efficient, they cannot replace the significant amount of direct care required by people with extensive physical and cognitive limitations. In the current system, workforce challenges — such as shortages and high

turnover — undermine access to quality care (Institute for the Future of Long Term Care Services 2007). Wage differentials limit the system's flexibility to deploy a shrinking workforce where it is needed most. More information is required to determine if or how employment arrangements (such as subcontracting for direct care services) affects worker turnover, quality of care, and cost.

A strategy to develop a workforce that is better trained and more equitably compensated is essential. In formulating such a strategy, it will be important to examine cost-effective ways to provide worker training and continuing education, and to evaluate worker competency. For example, regional consolidation of training programs could be both efficient and a catalyst for better education. A workforce strategy should also include a socially responsible solution for achieving equity in direct care wages (comparable pay for similar work) across the long-term care sector. While reducing the current wage gap between home attendants and home health aides in New York City is an important step, it will not be easily accomplished in the current economic climate. Wage increases and rising health insurance costs are in direct competition for the scarce dollars available. Nonetheless, it is important to keep in mind the practical barrier that wage inequity presents to system reform. For example, in the current system, when a beneficiary moves voluntarily from personal care to MMLTC, a new direct care worker is assigned — otherwise the worker would have to accept lower wages and benefits when switching programs. Potential reform strategies, such as achieving administrative savings through program consolidations, may hinge on having flexibility to reassign workers where they are needed most.

The state's workforce policy must also reflect the reality that there are two direct care workforces — paid workers and unpaid family caregivers — that increasingly work in tandem (Gibson and Houser 2007; Raphael and Cornwell 2008). Family members have no legal obligation to help but frequently do, and their contributions are significant. While family participation is not an explicit eligibility criterion for receiving long-term care, it is a common consideration that influences both eligibility determinations and service allocation decisions. In the current system, caregivers have no formal rights to information or services that would support their contributions (Levine et al. 2006). The effect of reform proposals on their participation and well-being should be carefully considered.

Finally, in light of workforce shortages, a reform agenda will need to determine the role consumer-directed care should play in a future service delivery system, including the extent to which beneficiaries may identify and hire their own workers. A reform strategy needs to consider whether to continue to provide the option through a single program (consumer-directed personal assistance program), or incorporate it more broadly into other programs. Although it is considerably smaller than the other programs highlighted in this report, the consumer-directed personal assistance program is growing rapidly — particularly outside New York City, as it is harder to recruit and retain direct care workers outside the city. Rising transportation costs may also be a factor in the growth of CDPAP in areas with limited or no public transportation.

Regulation, Oversight, and Quality Improvement

New York's strategy for providing long-term care has come a long way since the 1970s, when nursing homes were the predominant care setting. Despite significant changes in the way services are delivered and financed, the performance survey process remains the primary mechanism for evaluating program quality, focusing on ensuring minimal standards, such as no harm (beneficiary safety) as compared to facilitating good care (quality outcomes). In addition, as the system has grown, new regulations have been layered upon the old ones, rather than replacing them. For example, many of the physical plant requirements for nursing home construction have become inconsistent with modern-day thinking about how physical spaces should be organized in order to create more home-like living environments.

A reform agenda should consider how to make quality monitoring a more dynamic, data-driven process. It must also achieve greater balance between regulations designed to ensure beneficiaries' health and safety, and the freedom and flexibility required to provide high-quality care, such as creating more home-like nursing homes and other residential environments. Finally, since oversight responsibility for long-term care programs is divided between the Office of Long-Term Care and the Office of Health Insurance Programs within the State Department of Health, there must be a concerted effort to promote consistency in long-term care policy and regulation.

Conclusion

There is no escaping the reality that providing high-quality services to people who need extensive long-term care will require substantial resources — regardless of the provider, program, or setting. For example, the state will need substantial resources to care for nursing home beneficiaries, a population that on the whole is frailer and more medically complex than that served in community settings, and to update many of the facilities' aging infrastructures (Eljay 2008). At the same time, the state's community-based long-term care programs are also serving a population that has extensive needs; for example, roughly half of beneficiaries in community settings have some degree of cognitive impairment. Meeting the needs of a large population with cognitive impairment and other demanding conditions in the least restrictive setting (typically the home) may not be the most cost-efficient way to provide long-term care, especially if ensuring a beneficiary's health and safety requires 24-hour care. However, if providing individual in-home services is not financially sustainable, the state will need to pursue new alternatives that bridge the gap between current residential and community-based programs.

The next generation of long-term care policy will be crafted in challenging economic times. The pace of change will be influenced by external factors, such as workforce shortages, the scarcity of affordable housing, and widespread fraud and abuse investigations.³⁹ While these barriers are significant, they are not insurmountable.

A reform agenda for long-term care in New York should include strategies to:

- Provide timely information and guidance at points of entry and transition
- Simplify the long-term care system in ways that make it easier for beneficiaries and providers to understand and for government to regulate
- Promote more consistent implementation of policies and regulations
- Determine where additional capacity and capital improvements are warranted and the most efficient ways to finance them
- Routinely identify individuals who meet criteria for care management and determine how best to provide and pay for it
- More fully integrate Medicare and Medicaid financing and decide how to build on and incorporate existing provider capacity into these efforts
- Align payment to beneficiaries' level of need, through risk-adjusted per capita payments or other reimbursement strategies

³⁹ Part of the Federal-State Health Reform Partnership (F-SHARP) agreement that provides an additional \$1.5 billion in Medicaid financing to the state over five years was an agreement to bolster fraud and abuse recoveries in general and in the long-term care sector specifically.

- Develop a better trained and more equitably compensated workforce that can be readily deployed where it is needed most, and sustain and support family caregiver involvement
- Make quality monitoring a more dynamic, data-driven process

Effective responses to the challenges inherent to developing these strategies would benefit from the input of all of the key stakeholders: policymakers, beneficiaries, family members, advocates, labor unions, service providers, private sector leaders, and others. New York's progress will depend on many of the same factors that have contributed to its success thus far: cooperation and sustained leadership at all levels of government, a continued public policy commitment to providing high-quality care in the most integrated home-like settings, ongoing experimentation with new approaches, and progressive eligibility rules that ensure community care is a financially viable alternative to nursing home care.

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